STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-1010

TENNESSEE BOARD OF MEDICAL EXAMINERS
COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 24384 or
(615) 532-3202, ext. 24384
www.tennessee.gov

APPLICATION INSTRUCTIONS FOR LICENSURE AS AN ORTHOPEDIC PHYSICIAN ASSISTANT

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Committee.**

		Done
1.	Complete, sign, have notarized, and mail the application pages 1 through 6.	____
2.	Attach to the application a clear, recognizable, recently taken and notarized passport photograph of yourself.	____
3.	Complete and mail Attachment 1 to the institution at which you completed your orthopedic physician assistant program. Alternatively, if applying by exam/experience have supervising physician complete and have notarized Attachment 2.	____
4.	If you are or have ever been licensed, certified, registered, or permitted by any state to practice as an orthopedic physician assistant or other health professional, you must complete and mail Attachment 3 to each and every state. Copies of Attachment 3 may be made to accommodate each request.	____
5.	If you are a certified by the National Board for the Certification of Orthopedic Physician Assistants, you must complete and mail Attachment 4 to the Board for the Certification of Orthopedic Physician Assistants.	____
6.	Submit two (2) <u>original</u> letters of recommendation on letterhead from medical professionals who can attest to your character as an Orthopedic physician assistant. These letters must identify the individuals as medical professionals and must be originals.	____
7.	Submit a copy of your diploma from your orthopedic physician assistant program (if applicable).	____
8.	If you have a supervising physician, submit Attachment 5 along with your application. Attachment 5 <u>must</u> be signed by the supervising physician and must be submitted prior to beginning practice.	____
9.	Complete and mail the profile questionnaire pages 1 through 6.	____
10.	Attach to the application a check or money order in the amount of Three Hundred Thirty-Five Dollars ($335) made payable to the Committee on Physician Assistants.	____

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs <u>at any time, you must</u> notify the Committee's administrative office, in writing, immediately.

1. All **application fees are non-refundable.**

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Committee on Physician Assistants
First Floor, Cordell Hull Building
425 Fifth Avenue North
Nashville, TN 37247-1010

For Federal Express or Special Courier:
Committee on Physician Assistants
First Floor, Cordell Hull Building
425 Fifth Avenue North
Nashville, TN 37219

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you <u>will</u> be responsible for charges incurred. The Committee asks that you please give the administrative office every consideration in this matter.

4. **We will discuss application status with the applicant or applicant's spouse <u>only</u>.** Please inform hospitals, employers, recruiters, referral companies, or insurance companies that application status updates must be obtained from you.

5. If necessary documentation has not been received when your application is received in the Committee's administrative office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Committee's administrative office <u>sixty (60) days</u> from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

ATTACH A CURRENT FULL-FACE PHOTOGRAPH (NOTARIZED)

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-1010

FOR OFFICIAL USE ONLY

3629-001	**$325**
3629-006	**$ 10**
	$335

TENNESSEE BOARD OF MEDICAL EXAMINERS
COMMITTEE ON PHYSICIAN ASSISTANTS
APPLICATION FOR LICENSURE
ORTHOPEDIC PHYSICIAN ASSISTANT

(800) 778-4123, ext. 24384 or
(615) 532-3202, ext. 24384
www.tennessee.gov

Choose the appropriate license category for which you qualify. See the Practice Act and the rules and regulations to determine the requirements for each category of practitioner and licensure.

CERTIFICATION ALTERNATIVES

A._____ Orthopedic Physician Assistant Licensure by Exam/Education

B._____ Orthopedic Physician Assistant Licensure by Exam/Experience

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: _____
Last First Middle Maiden

Social Security Number: ___ - ___ - ___ Date of Birth: _____

Mailing Address: _____
(Residence)

_____

_____

Phone: Home: (___) ___ - _____ Office: (___) ___ - _____

Place of Birth: _____ Sex: (optional-for statistical purposes only)
Female _____ Male _____

U.S. Citizen: Yes ___ No ___

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back page of this page if you need additional space. (SEND ATTACHMENT 1 TO THE EDUCATIONAL INSTITUTION WHERE YOU COMPLETED YOUR OPA PROGRAM.)

From: _________ To: _________ ___________________________________ ____________________________
Mo/Yr Mo/Yr Educational Institution/Physician Asst. Program **Location**

From: _________ To: _________ ___________________________________ ____________________________
Mo/Yr Mo/Yr Educational Institution/Physician Asst. Program **Location**

From: _________ To: _________ ___________________________________ ____________________________
Mo/Yr Mo/Yr Educational Institution/Physician Asst. Program **Location**

From: _________ To: _________ ___________________________________ ____________________________
Mo/Yr Mo/Yr Educational Institution/Physician Asst. Program **Location**

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES LOCATION POSITION AND DUTIES

From:_______ To: _______ _____________________________ _____________________________________
Mo/Yr Mo/Yr (City) (State) _____________________________________

From:_______ To: _______ _____________________________ _____________________________________
Mo/Yr Mo/Yr (City) (State) _____________________________________

From:_______ To: _______ _____________________________ _____________________________________
Mo/Yr Mo/Yr (City) (State) _____________________________________

From:_______ To: _______ _____________________________ _____________________________________
Mo/Yr Mo/Yr (City) (State) _____________________________________

From:_______ To: _______ _____________________________ _____________________________________
Mo/Yr Mo/Yr (City) (State) _____________________________________

From:_______ To: _______ _____________________________ _____________________________________
Mo/Yr Mo/Yr (City) (State) _____________________________________

From:_______ To: _______ _____________________________ _____________________________________
Mo/Yr Mo/Yr (City) (State) _____________________________________

From:_______ To: _______ _____________________________ _____________________________________
Mo/Yr Mo/Yr (City) (State) _____________________________________

From:_______ To: _______ _____________________________ _____________________________________
Mo/Yr Mo/Yr (City) (State) _____________________________________

From:_______ To: _______ _____________________________ _____________________________________
Mo/Yr Mo/Yr (City) (State) _____________________________________

CERTIFICATION INFORMATION

List below ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED as an orthopedic physician assistant. Additional pages may be added if necessary. Submit a copy of Attachment 3 to all such states, countries, or provinces regarding such licensure, certification, or permit.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below ALL states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than an orthopedic physician assistant. Additional pages may be added if necessary. Submit a copy of Attachment 3 to all such states, countries, or provinces regarding such licensure, certification, or permit.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

		Yes	No
1.	Are you certified by the National Board for the Certification of Orthopedic Physician Assistants **(NBCOPA)? If so, complete Attachment 3** and send it to the N.B.C.O.P.A.	____	____
2.	Have you ever applied for an orthopedic physician assistant license in Tennessee?	____	____
3.	Have you ever received a license in Tennessee?	____	____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnosis (if necessary), exercise reasoned judgments, to learn, and keep abreast of developments in your profession;

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	____	____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	____	____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	____	____

[*If you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]*

COMPETENCY INFORMATION CONTINUED

QUESTIONS	Yes	No
2. Do you currently use chemical substances as defined on page 4?	____	____
If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	____	____
Please list: _____		
3. Are you currently engaged in the illegal use of controlled substances?	____	____
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	____	____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	____	____
5. If you have ever held or applied for a license or certificate to practice as an orthopedic physician assistant in any state, country, or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	____	____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	____	____
8. Have you ever been rejected or censured by a professional society?	____	____
9. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you;	____	____
b. Have you ever had settlement of any legal action rendered against you; or	____	____
c. Are there any legal actions pending against you or to which you are a party?	____	____
10. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered under threat of investigation, or disciplinary action?	____	____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn and
(Applicant's Name) (City) (State)
identified as the person referred to in this application attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations, which were enclosed in the application packet, and agree to abide by them in the practice as an orthopedic physician assistant in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Committee and Board may find necessary, which may include a full Board or Committee interview.

RELEASE to the Committee and Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as an orthopedic physician assistant.

AUTHORIZE the Committee and Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications:

RELEASE from liability the Committee and Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me this _____ day of _____, _____.

_____ Affix Seal Here
NOTARY PUBLIC

My Commission expires: _____

ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-1010

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 24384 or
(615) 532-3202, ext. 24384
www.tennessee.gov

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your orthopedic physician assistant program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a certificate to practice as an orthopedic physician assistant in the State of Tennessee. The Committee on Physician Assistants requires verification of educational attainment. Please forward an original transcript bearing the institution's official seal and date degree conferred to the Committee's address below.

Applicant's Full Name: _____
(Last) (First) (Middle/Maiden)

Applicant's Address: _____

_____

_____

_____

Applicant's Social Security Number:_____- _____ - _____

Applicant's Student Identification Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred:_____

Please forward an original graduate transcript bearing the institution's official seal to:

Committee on Physician Assistants
First Floor, Cordell Hull Building
425 Fifth Avenue North
Nashville, TN 37247-1010

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature **Date**

ATTACHMENT 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-1010

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 24384 or
(615) 532-3202, ext. 24384
www.tennessee.gov

AFFIDAVIT OF EMPLOYMENT
ORTHOPEDIC PHYSICIAN ASSISTANT

I, _____ License Number _____, being duly
(Medical Doctor or Osteopathic Physician)

sworn hereby certify that _____
(Orthopedic Physician Assistant - type or print name)

was performing service as an orthopedic physician assistant in _____ on _____.

These services were performed at _____
(Facility or Practice Setting)

_____
(City, State, and Zip Code)

_____ _____
(Signature of Physician) (Date)

Sworn to before me this the _____ day of _____, _____.

_____
NOTARY PUBLIC

Affix Seal Here

My Commission expires: _____

ATTACHMENT 3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-1010

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 24384 or
(615) 532-3202, ext. 24384
www.tennessee.gov

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one (1) form to the licensure board in EACH state where you **hold** or **have ever held** a license to practice any profession. (Copies of this form can be used.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a (**circle one**) license or certificate to practice _____
(Profession)
numbered _____ on _____ in the State of _____. The Committee on
(Date)
Physician Assistants of Tennessee requests that I submit evidence of the current status of that license in your state.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Committee on Physician Assistants.

_____
Applicant's Signature

Date:_____

_____
Applicant's typed or printed name

To Be Completed By Administrative Office of State Licensure Board

Name In Full As it Appears On License/Certificate or Permit:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number:_____ Profession:_____

Date Issued:_____ Expiration Date: _____

Basis of Issuance:_____ Endorsement/Reciprocity with _____
(Check One) (State)
_____ Written Examination _____

Is the License currently active and registered? Yes _____ No _____

Is there any derogatory information on file? Yes _____ No _____
If yes, please attach supporting documentation.

_____ _____ _____
Authorized Signature Title Date

Please mail directly to:
Committee on Physician Assistants
First Floor, Cordell Hull Building
425 Fifth Avenue North
Nashville, TN 37247-1010

ATTACHMENT 4

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-1010

COMMITTEE ON PHYSICIAN ASSISTANTS
(800) 778-4123, ext. 24384 or
(615) 532-3202, ext. 24384
www.tennessee.gov

NBCOPA VERIFICATION

Only if or when you are credemtialed with the N.B.C.O.P.A., please complete this form and mail it to the address below.

National Board for the Certification of Orthopedic Physician Assistants
c/o ASOPA Headquarters Speciality Society Services AAOS
6300 North River Road, Ste. 727
Rosemont, Il 60018-4226

To Be Completed By Applicant (Please Print In Ink)

Dear N.B.C.O.P.A. Official:

I am applying for a license to practice as an Orthopedic Physician Assistant in the State of Tennessee. The State Board of Medical Examiner's Committee on Physician Assistants requires verification be forwarded directly to their office by the N.B.C.O.P.A.

Applicant's Name _____
(First) (M.I.) (Last)

Social Security No.: _____ - _____ - _____ Credential # _____

To Be Completed by NBCOPA

Name applicant tested by if different from above:

_____
(First) (M.I.) (Last)

Date Certified _____ Basis of Examination _____

_____
(N.B.C.O.P.A. Official's Signature)

Please mail directly to: **Committee on Physician Assistants**
First Floor, Cordell Hull Building
425 Fifth Avenue North
Nashville, TN 37247-1010

PH-3562
(Rev. 02/04)

RDA 1786

ATTACHMENT 5

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
NASHVILLE, TN 37247-1010

COMMITTEE ON PHYSICIAN ASSISTANTS

SUPERVISING PHYSICIANS

This section must be completed by the supervising physician(s). (This page may be duplicated if necessary.)

List all practice settings:

1) Setting: *

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

1) Setting: *

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

1) Setting: *

_____
Supervising Physician Signature

_____
Printed Name

_____
Address

_____
Tennessee Medical License Number

LP/G6077217/PA